

141117

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be delivered for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 15398			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
John Combs					Abell	May 10, 1985									
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		# UNDER 24 HRS			
Male		White		Sept. 28, 1913			71			MONTHS	YEARS	HOURS	MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Md.		U.S.A.					St. Mary's								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
California		Home			Self Employed										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		P.O. Box 153 (20619)					
Md.		St. Mary's		California											
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
John Combs				Abell	Henrietta			J.		Joy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS								
No		219-05-1922A		Agnes E. Abell, Same as 13e.											
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE 1a) <i>relentless Cancer</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs.</i>			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause lost</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>4-81</i>			CITY OR TOWN <i>570-85</i>			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>5-6-85</i> 19 to <i>5-14-85</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Wm D. Boyd</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>5-14-85</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
William D. Boyd II, M.D.		Leonardtown, Maryland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL CHARLES MEMORIAL GDNS.			23d. LOCATION CITY OR TOWN			23e. COUNTY		23f. STATE			
Burial		5/13/85					Leonardtown, St. Mary's								
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
W. Clarke Mattingley, Leonardtown, Md.					MAY 17 1985			<i>W. D. Boyd</i>							

卷之三

155080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										15399 REG. NO.						
1 - STATE REGISTRAR			2a. DATE OF DEATH							MONTH	DAY	YEAR	2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		05 27 85			0303 M			
3. SEX			4. RACE			5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
m			w			MONTH 4 DAY 17 YEAR 36		49			MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
PHILA. PA.			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			ST. MARYS							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
PATUXENT RIVER			NAVAL HOSPITAL PATUXENT RIVER			13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS				
MD ST. MARYS			LEXINGTON PK			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. INSIDE CITY LIMITS?			100 CECIL Rd. 21762				
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST	
JOHN COOPER			ADAMS			ANA			MAN			WILSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
YES			149-26-87			44 CORALIE ADAMS			100 CECIL Rd.			- 2 hours				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																
DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 0128 27 May 19 85, to 0303 27 May 19 85, that (I) (we) last saw the deceased alive on 0303 27 May 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Dennis Ray Stevenson MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 27 May 85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS RAY STEVENSON			22e. ADDRESS 5318 MCKINNEY BETHESDA, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE BURIAL 6-3-85			23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL			23d. LOCATION CITY OR TOWN ARLINGTON			COUNTY		STATE		
24. FUNERAL DIRECTOR EDWARD N. BRINSFIELD, JR.			ADDRESS LEONARDTOWN, MARYLAND			25a. DATE REC'D. BY REGISTRAR MAY 31 1985			25b. REGISTRAR'S SIGNATURE Edward N. Brinsfield							

122080

122080

MEDICAL CERTIFICATION

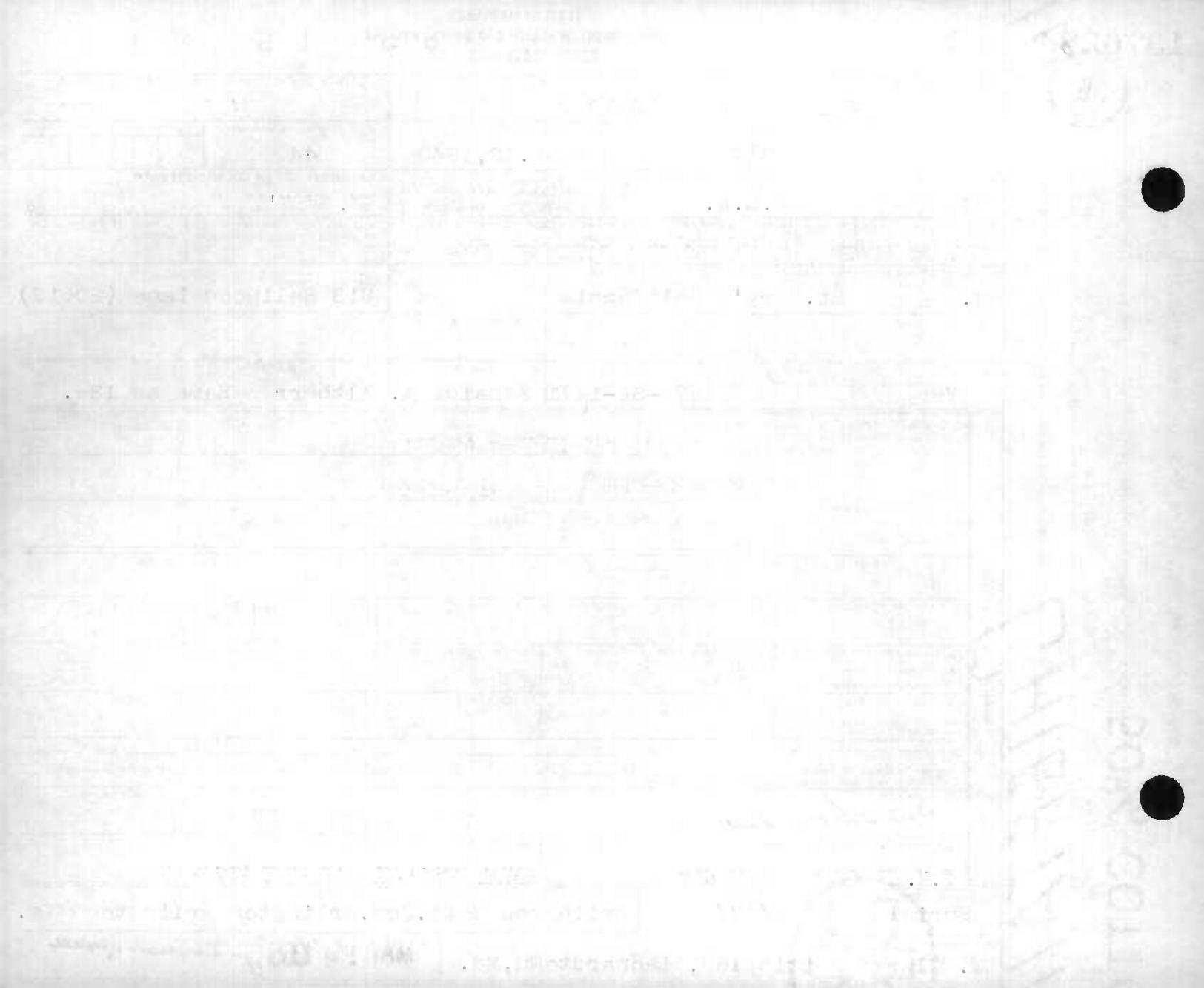
1 - FOR  
STATE  
REGISTRATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15400  
REG. NO.

REF ID: NC

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
KENNETH JOHN ALTHERR						5/8/85				0741A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 13, 1940			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR				
							44		MONTHS	DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MI		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD.						
10. CITY OR TOWN OF DEATH PATUXENT RIVER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL PATUXENT RIVER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.						13b. COUNTY St. Mary's		13c. CITY OR TOWN California		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 813 Bellwood Lane (20619)	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Yes			17. INFORMANT Zenaida A. Altherr			ADDRESS Same as 13e.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any: DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Dr. Shodhan</u>		22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. N. SHODHAN CDR MC USN		22e. ADDRESS NAVAL HOSPITAL PATUXENT RIVER MD			22f. DATE SIGNED								
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 5/13/85		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.			23d. LOCATION TOWN CITY STATE		25a. DATE REC'D. BY REGISTRAR MAY 14 1985				
24. FUNERAL DIRECTOR W. Clarke Mattingley		ADDRESS Leonardtown, Md.			25b. REGISTRAR'S SIGNATURE <u>John W. Mattingley</u>								



## TO HOSPITAL OR ATTENDING PHYSICIAN. The attended by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 2 hours after death.

WITH THE STATE DEPT. OF HEALTH AND MUNICIPAL HYGIENE prior to burial, entombment, or removal.

MEMORANDUM: If Item 2 is marked as Item 1B below, any injury, or other traumatic event, its medical outcome may be certified on page 4.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15401  
REG. NO.

REG. NO.

149027

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Vick</i>	MIDDLE <i>Barbitta</i>	LAST	2a. DATE OF DEATH MONTH DAY YEAR	MONTH DAY YEAR	2b. HOUR 4:45 PM
3. SEX <i>Male</i>	4. RACE <i>cauc.</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>2 - 4-1893</i>	6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>ITALY</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>ST. MARY'S Co.</i> MD.				
10. CITY OR TOWN OF DEATH <i>Lexington Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Amber House</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>retired-HEALER</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>BAKERY</i>				
13a. STATE <i>MD.</i>		13b. COUNTY <i>P. G. C.</i>	13c. CITY OR TOWN <i>Riverdale</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>4803 Queensbury Road 20737</i>			
14. FATHER'S NAME FIRST <i>JOSEPH</i>		MIDDLE <i></i>	LAST <i>BARBITTA</i>	15. MOTHER'S MAIDEN NAME FIRST <i>TINA</i>	MIDDLE <i></i>	LAST <i>NATOLI</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>577-052479</i>		17. INFORMANT <i>FRANK J. BARBITTA</i>	ADDRESS <i>4811 QUEENSBURY RD RIVERDALE, MD. 20737</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Aspiration Pneumonia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2-3 day</i>								
DO TO, OR AS A CONSEQUENCE OF (b) <i>Cerebrovascular Accident</i> <i>Master</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
DO TO, OR AS A CONSEQUENCE OF (c) <i></i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Diabetes Mellitus.</i>								
19a. DATE OF OPERATION <i></i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i></i>				
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <i></i>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i></i>			21f. LOCATION STREET <i></i>	CITY OR TOWN <i></i>	COUNTY <i></i>	STATE <i></i>	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>3/15</i> 19 <i>85</i> to <i>5/21</i> 19 <i>85</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>5/21</i> 19 <i>85</i> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) did not view the body after death.								
22b. SIGNATURE <i>David C. Allen</i>		DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>5/22/85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>David C Allen</i>		22e. ADDRESS <i>Box 601 Leonardtown, Md. 20650</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>MAY 24, 1985</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>FT. LINCOLN CEM.</i>	23d. LOCATION CITY OR TOWN <i>BRENTWOOD P.C. Md.</i>	23e. COUNTY <i></i>	23f. STATE <i></i>		
24. FUNERAL DIRECTOR NAME <i>W. W. CHAMBERS Co.</i>		ADDRESS <i>20737 RIVERDALE, Md.</i>	25a. DATE REC'D. BY REGISTRAR <i>MAY 24 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>			

مکتبہ

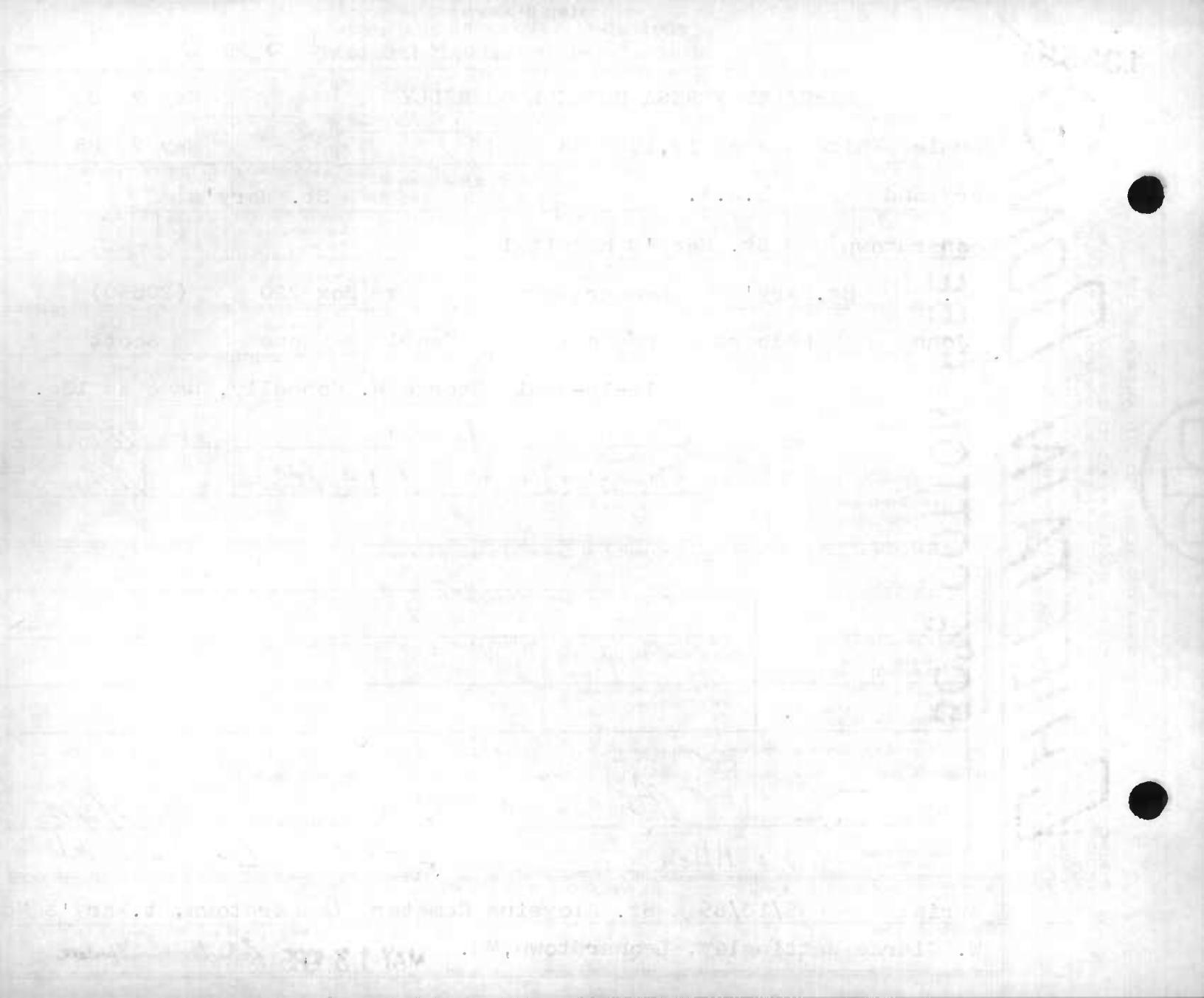
135591

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH5 402  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR		2b. HOUR		
MARGARET TERESA RUSSELL CONNELLY						<input type="checkbox"/> May 7 1985				M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) T.S.	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR		
Female	White	March 19, 1922	63	MONTHS	DAYS	May 7 1985				M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's			
Maryland		U.S.A.							MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Leonardtown		St. Mary's Hospital										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		ADDRESS		
Md.		St. Mary's		Leonardtown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 220		(20650)		
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
John		Melbert		Russell		Pearl		Rose		Scott		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			216-16-4441			George W. Connelly, Same as 13e.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <u>Minutes</u>												
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u> (b) <u>Myocardial Infarction</u> (c) <u>Minutes</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>David Allen</i>		TITLE (SPECIFY) M.D. <i>Deputy</i>			MEDICAL EXAMINER			DATE SIGNED <i>5/9/85</i>				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			Box 601 Leonardtown Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		5/10/85		St. Aloysius Cemetery			Leonardtown, St. Mary's		Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
W. Clarke Mattingley, Leonardtown, Md.					MAY 13 1985		<i>Sylvia Franklin Pendall</i>					



5403  
REG. NO.

158093

**DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201**

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. SEE PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE ERED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

7/8.  
5M

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))

DHMH - 17  
(VR A15 ME (5))

DIVISION OF VITAL RECORDS 201 W. DEADERICK ST. BALTIMORE MD 21201

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI. DEATH MATED			MONTH DAY YEAR			2b. HOUR					
GERALD ROBERT CRIST						<input checked="" type="checkbox"/>						5 28 19 85		M			
1. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 23 1956</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>28</b>	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.							2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
			YRS. <b>28</b>									<b>5 28 19 85</b>		12:40 AM			
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County</b>								
10. CITY OR TOWN OF DEATH <b>Leonardtown</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IE NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Automobile Painter</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Auto Body</b>								
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>			13c. CITY OR TOWN <b>Oxon Hill</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>7100 Southlawn Dr.</b>			20745		
14. FATHER'S NAME FIRST <b>Gerald</b>			MIDDLE <b>P.</b>			LAST <b>Crist</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b>			MIDDLE <b>J.</b>			LAST <b>Danemark</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IE YES, GIVE WAR OR DATES) <b>1975 - 1976</b>			16c. ADDRESS <b>220-66-7990</b>			17. INFORMANT <b>Gerald P. Crist</b>			17. ADDRESS <b>7100 Southlawn Dr. Oxon Hill, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of chest (handgun)</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause</u> lost. (b) DUE TO, OR AS A CONSEQUENCE OF																	
(c) DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? <b>BODY ONLY</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <b>xx</b> MONTH DAY YEAR <b>11:30M 5-27- 1985</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Self-inflicted.</b>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>house</b>			21f. LOCATION STREET <b>Rt. 6 on Delabrooke Rd.</b>			CITY OR TOWN <b>St. Mary's</b>			COUNTY <b>MD</b>		STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE <i>Ann M. Dixon</i> TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER																	
DATE SIGNED <b>5-28-85</b>																	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS <b>111 Penn St., Balto., MD 21201</b>														
23a. BURIAL, CREMATION, REMOVAL (SPECIES)			23b. DATE <b>5/31/85</b>			23c. NAME OF CEMETERY OR CREMATORIUM <b>Alto Reste Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Alteona</b>			COUNTY <b>Blair</b>		STATE <b>Pennsylvania</b>			
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b>			ADDRESS <b>6160 Oxon Hill Rd. Oxon Hill, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>11 JUN 03 1985</b>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendleton</i>								

George

George

the next of kin in case of his

death or disappearance

and contact with him

and his family

and his wife and children

and his

and his wife and children

and his

and his wife and children

and his

and his wife and children

and his

and his wife and children

and his

and his wife and children

and his

and his wife and children

and his wife and children

155063

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 15404						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
James Otha Currie												May 26, 1985					M	
3. SEX Male			4 RACE White			5 DATE OF BIRTH July 31, 1933						6 AGE (IN YEARS LAST BIRTHDAY) 51		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Leonardtown, Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.						
10 CITY OR TOWN OF DEATH Leonardtown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY St. Mary's			13c. CITY OR TOWN Hollywood			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Rt. 2 Box 102		20636				
14. FATHER'S NAME FIRST Jessie			MIDDLE Carroll			LAST Currie			15. MOTHER'S MAIDEN NAME FIRST Pearl			MIDDLE Agnes		LAST Brown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-32-8227			17. INFORMANT Catherine Genevieve Currie						ADDRESS same as 13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Jumed.						
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>												C. hr.						
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>												unknown						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 5-28-85						
22b. SIGNATURE <u>John F. Fenwick, M.D.</u> DEGREE												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. Fenwick M.D.			22e. ADDRESS Leonardtown, Md. 20650															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 29, 1985			23c. NAME OF CEMETERY OR CREMATORIAL St. John's Cemetery			23d. LOCATION CITY OR TOWN Hollywood		COUNTY	STATE						
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley			ADDRESS Leonardtown, Md.			25a. DATE REC'D. BY REGISTRAR MAY 31 1985			25b. REGISTRAR'S SIGNATURE									

230000

17

157069

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

15405

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MARY	MIDDLE HATTIE	LAST DOUGLAS	2a. DATE OF DEATH May 30, 1985	MONTH DAY YEAR	2b. HOUR 7:49 P M	
3. SEX Female		4. RACE Black	5. DATE OF BIRTH MONTH Nov. 1, 1928 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.			
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.		13b. COUNTY St. Mary's	13c. CITY OR TOWN Mechanicsville	13d. INSIDE CITY LIMITS? like <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rt. 3, Box 89 (20659)				
14. FATHER'S NAME FIRST Theodore		MIDDLE Thomas	LAST	15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE Lena	LAST Medley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-54-6398		17. INFORMANT Harrison E. Douglas		ADDRESS Same as 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Malignant Cancer of the rectum 4 yrs.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.		DUE TO, OR AS A CONSEQUENCE OF (b)							
		DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>William D. Boyd II</i>		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED 5-31-87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Boyd II, M.D.		22e. ADDRESS Leonardtown, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/3/85	23c. NAME OF CEMETERY OR CREMATORIAL Charles Memorial Gdns. Leonardtown, St. Mary's		23d. LOCATION CITY OR TOWN Md.	23e. COUNTY	23f. STATE		
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.		25a. DATE REC'D. BY REGISTRAR JUN 4 1985							
		25b. REGISTRAR'S SIGNATURE <i>William Mattingley</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If more than 24 hours elapse, the physician should be recontacted.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, the Office of Burial, Cremation and Removal.

IMPORT AND IF Item 21d marked either (B) or (C) any injury, or other traumatic event, the medical examiner should be recontacted.

20070

134564

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM-3. RETAIN PAGE 5 FOR YOUR USE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PHESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5406				
1. DECEASED NAME (TYPE OR PRINT)			FIRST ELLEN			MIDDLE MARIA			LAST FILIPSON			2a. DATE KNOWN OF DEATH ESTI- MATED	□ MONTH MAY	DAY 5	YEAR 85	2b. HOUR STAY
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH MAY YEAR 1890	6. AGE (IN YEARS LAST BIRTHDAY) 94	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH MAY	DAY 5	YEAR 85	2d. HOUR M						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RHODE ISLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED WIDOWED X			9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S							
10. CITY OR TOWN OF DEATH LEXINGTON PARK			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 447 TOWN CREEK DRIVE			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MARYLAND	13b. COUNTY ST. MARY'S	13c. CITY OR TOWN LEXINGTON PK.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/>	13e. STREET ADDRESS 447 TOWN CREEK DRIVE 20653	13f. LAST											
14. FATHER'S NAME FIRST CHARLES			15. MOTHER'S MAIDEN NAME FIRST MARTA			16. SOCIAL SECURITY NO. 261-43-5396			17. INFORMANT ADDRESS 447 TOWN CREEK DRIVE MRS. ELNA HELGERSON, LEXINGTON PARK, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Death - Probable Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE					
22a. I certify that I took charge of the remains described above, held on _____ death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>David Allen, M.D.</u>												22b. TITLE (SPECIFY) M.D. / Deputy	22c. MEDICAL EXAMINER			
EXAMINER'S NAME TYPE OR PRINT) DAVID ALLEN, M.D.			ADDRESS MEDICAL ARTS BLDG., LEONARDTOWN, MD.			DATE SIGNED 5/3/85										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/11/85			23c. NAME OF CEMETERY OR CREMATORIAL NORTH PURCHASE			23d. LOCATION CITY OR TOWN ATTLEBORO, BRISTOL, MASS.							
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR.,			ADDRESS P.O. BOX 279 LEONARDTOWN, MD.			25a. DATE REC'D. BY REGISTRAR MAY 9 1985			25b. REGISTRAR'S SIGNATURE Julia Davis							
DHMH - 17 (VR A15 ME (5))																
15M 7/77																



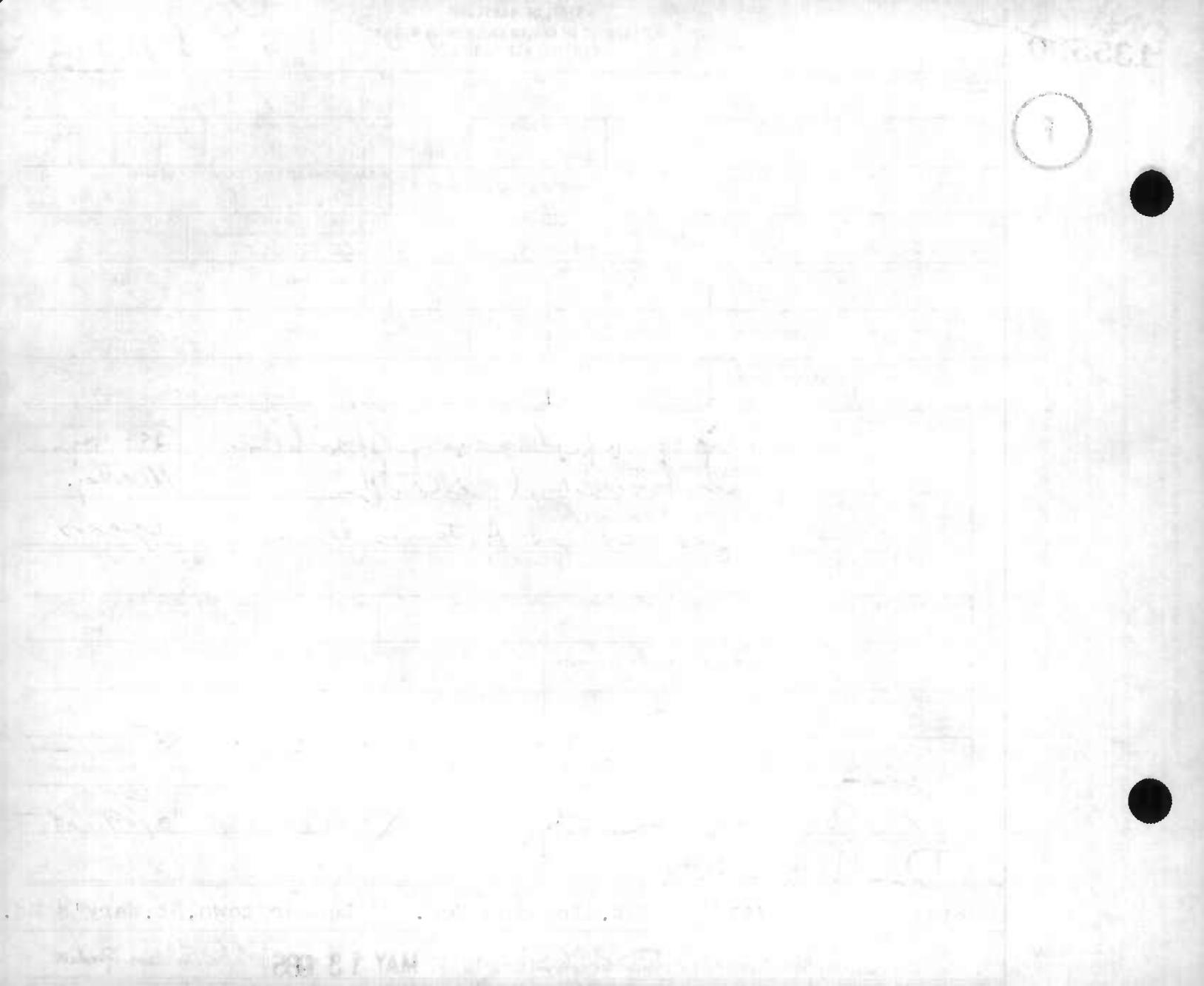
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Item 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in for the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

## MEDICAL CERTIFICATION

1. DECEASED NAME				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR						
WILLIAM				FLECKENSTEIN			MAY 8, 1985										
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Male		White		Month Day Year May 23, 1894			90 YRS.				MONTHS	DAYS	HOURS	MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				10. CITY OR TOWN OF DEATH						
New York		USA					St. Mary's				Leonardtown						
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
St Mary's Nursing Home				Carpender													
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		201619					
Maryland				St Mary's		California		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO				17. INFORMANT						
FIRST Paul				LAST Fleckenstein			109-03-2441				Veronica Abell Fleckenstien						
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				18b. SOCIAL SECURITY NO				18c. ADDRESS				above same as					
No																	
18d. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				18e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				Gordy pulmonary failure				3 days									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF Intracerebral event				10 days									
				DUE TO, OR AS A CONSEQUENCE OF Generalized Arterosclerosis				years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		21f. LOCATION STREET		CITY OR TOWN		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 85 Oct 1980 to 5/7 1985, that (I) (we) last saw the deceased alive on 5-3 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 5/9/85					
22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22d. DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
Dr. Mossman																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE 5/11/85		23c. NAME OF CEMETERY OR CREMATORIAL St. Aloysius Cem.		23d. LOCATION CITY OR TOWN Leonardtown, St. Mary's Md.		25a. DATE REC'D. BY REGISTRAR MAY 13 1985				25b. REGISTRAR'S SIGNATURE Lisa Davidson Pendell			
Burial																	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtown, Maryland													



148098

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH15408  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
			JOHN	CHESTER	HAHN	May 19, 1985			11:50 P.M.			
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male			White	Nov. 26, 1919			65			YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.			
Pa.			U.S.A.									
10. CITY OR TOWN OF DEATH Leonardtown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) St. Mary's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Service			12b. KIND OF BUSINESS OR INDUSTRY Diebold			
13a. STATE Md.			13b. COUNTY St. Mary's	13c. CITY OR TOWN Compton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE General Delivery 20621				
14. FATHER'S NAME FIRST Chester			MIDDLE	LAST Hahn	15. MOTHER'S MAIDEN NAME FIRST Barbara			MIDDLE	LAST Diebold			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 172-14-8620			17. INFORMANT Robert P. Hahn			ADDRESS 352 Pineview Dr. Columbus, Ohio 43213			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) <i>cardiovascular accidents, multiple</i>									
			(c) <i>undetermined</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death, _____)												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5-21-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. Fenwick, M.D.			22e. ADDRESS Leonardtown, Maryland 20650									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/23/85	23c. NAME OF CEMETERY OR CREMATORY St. Francis Xavier			23d. LOCATION CITY OR TOWN Compton			COUNTY St. Mary's	STATE Md.	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR MAY 23 1985			25b. REGISTRAR'S SIGNATURE J. Anderson-Mattingley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death, if performed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

800861

00:50

2019 1 1 10:50

HEAR

RECORD

2019

2019 1 1 10:50

2019 1 1 10:50

2019 1 1 10:50

2019 1 1 10:50

2019 1 1 10:50

2019 1 1 10:50

141010

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED (WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL).

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5409				
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR				
			Nicole Patricia Hall						<input checked="" type="checkbox"/> 5 10 1985			M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR	
FEMALE		WHITE		SEPT. 20, 1984		YRS. 7 20						5 10 1985			1:03P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH								
MARYLAND		U.S.A.		<input checked="" type="checkbox"/>		<input type="checkbox"/>		St. Mary's County								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Patuxent		Naval Air Station Hospital						NONE			NONE					
13a. STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN LEXINGTON PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS C 15 LORD CALVERT Trailer Crt.			20653					
14. FATHER'S NAME JOHN		MIDDLE T. R.		LAST HALL		15. MOTHER'S MAIDEN NAME ABIGAIL		16. ADDRESS VXN 8 BOX 224 PATUXENT RIVER, MD.			M. RIPLEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ABIGAIL M. RIPLEY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9104 IMMEDIATE CAUSE (a) Drowning Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <del>XX</del> MONTH DAY YEAR 12:30M 5 10 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject drowned in bathtub			<input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION STREET Lord Calvert Trailer Park, Great Mills, St. Mary			COUNTY MD							
22a. I certify that I took charge of the remains described above, held or death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Thomas D. Smith</i>																
TITLE (SPECIFY) M.D. Acting Chief MEDICAL EXAMINER																
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St. Balto. MD.						DATE SIGNED 5/11/85							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 5-13-85			23c. NAME OF CEMETERY OR CREMATORIAL HUNTT CREMATORY			23d. LOCATION CITY OR TOWN WALDORF			COUNTY CHARLES		STATE MARYLAND		
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR.			ADDRESS Leonardtown, Maryland						25a. DATE REC'D. BY REGISTRAR MAY 15 1985			25b. REGISTRAR'S SIGNATURE <i>Julie Swanson-Pender</i>				
25b. REGISTRAR'S SIGNATURE <i>Julie Swanson-Pender</i>																

010161



148092

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use of the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 15410				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
FLORENCE LOUISE HEBB						May 19, 1985						4:40 A.M.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female			Black			MONTH DAY YEAR March 5, 1917			68			MONTHS	YEARS	MONTHS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Leonardtown			St. Mary's Hospital													
13a. STATE Md.			13b. COUNTY St. Mary's			13c. CITY OR TOWN Mechanicsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt. 1, Box 136 (20659)				
14. FATHER'S NAME FIRST Joseph			MIDDLE Barber			15. MOTHER'S MAIDEN NAME FIRST Maggie			MIDDLE LAST ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			P.O. Box 344 Margaret Ann Holt, MechCnicsville, Md.				
No			218-54-8867													
18. CAUSE OF DEATH (Enter only one cause per line for 18a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebrovascular Accident</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DO TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												(b) _____				
DO TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Aspiration pneumonia + respiratory Failure</u>																
19a. DAY OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/16</u> to <u>5/19</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (TYPE OR PRINT)			22d. ADDRESS			Leonardtown, Maryland 20650			22e. DATE SIGNED							
James C. Boyd, M. D.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Charles Mem. Gdns.			23d. LOCATION CITY OR TOWN			COUNTY				
Burial			5/24/85						Leonardtown			St. Mary's Md.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
W. Clarke Mattingley, Leonardtown, Md.									MAY 23 1985			John Davidson - Sandell				

1900-1910

608

2005.05.24

100

JOURNAL OF

## Intergovernmental cooperation

Open Textbooks.org

135589

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH15411  
REG. NO.

1. DECEASED NAME [TYPE OR PRINT]			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
LAWERENCE LAVENDEE JACOBS						MAY 04 1985			9:00P M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE [IN YEARS LAST BIRTHDAY]		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
MALE		CAUC		MAY 27 1912			72					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARYS'				
VIRGINIA		USA										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
LEXINGTON PARK		NAVAL HOSPITAL, PATUXENT RIVER, MD										
13. STATE MD		14. COUNTY CALVERT		13c. CITY OR TOWN SOLOMANS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 44E OVERLOOK, DR; DRUM PT; LUSBY, MD				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
UNKNOWN		Joseph M. Jacobs				Caroline /UNKNOWN Bradford Green						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS WITH ASCITES APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
YES		225-10-1718			LAVADA PHILIPS JACOBS S.A.A.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS WITH ASCITES												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <input checked="" type="checkbox"/> HEPATOMA										
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 PROBABLE HEPATOMA												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [IF EITHER, NOTIFY MEDICAL EXAMINER]		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 30 APR 1985 to 4 MAY 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4 MAY 1985, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I certify that I have viewed the body of the deceased.)												
22b. SIGNATURE		22c. DATE SIGNED										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>								
DAVID H. RATCLIFF, LCDR, MC, USN		NAVAL HOSPITAL, PATUXENT RIVER, MD 20670										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Burial		May 8, 1985		Arlington National			Arlington, Arlington, Va.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
W. Clarke Mattingley		Leonardtown, Maryland		MAY 13 1985			Suzi Friedman Pendleton					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death. Page 4 may be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3

should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certificate must be completed above.

F  
1570701. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH15412  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Joseph Horace Long						May 29, 1985					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Oct. 29, 1909		75		YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Md.		U.S.A.				St. Mary's					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Chaptico		Home				Farmer		Box 68 (20621)			
13a. STATE Md.		13b. COUNTY St. Mary's		13c. CITY OR TOWN Chaptico		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Old Chaptico Wharf Rd.			
14. FATHER'S NAME Richard		MIDDLE P.	LAST Long	15. MOTHER'S MAIDEN NAME Rachael		MIDDLE Ann	LAST Buckler				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 578-36-2802A		17. INFORMANT Josephine Long, Same as 13e.		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: Cerebral vascular accident (stroke)											
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Previous Cerebral Vasc. Accid. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____											
DUE TO, OR AS A CONSEQUENCE OF Diabetes Mellitus/Hypertension (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) this hospital attended the deceased from 1968, 19, to demise, 19, that (I) (we) lost saw the deceased alive on 5/29/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE		22c. DEGREE		22d. DATE SIGNED							
22e. ADDRESS		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22f. PHYSICIAN'S NAME Eugene Guazzo, M.D.		22g. ADDRESS Maryland Infirmary, Chaptico 20621									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE June 1, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Charles Memorial		23d. LOCATION CITY OR TOWN Gdns. Leonardtown, St. Mary's		COUNTY Md.		STATE Md.	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUN 4 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Henderson					

070748

negative and the

negative of the same, the minimum of

(or the)  $\delta$  of the negative of the

local and local

local negative

negative, the

negative of the

15413  
REG. NO.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO HOSPITAL OR ATTENDING PHYSICIAN.** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR.** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-troune permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the records of the funeral home.

**TO THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE.** Please forward the original certificate to the State Department of Health and Mental Hygiene, Albany, New York, within 10 days of the death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The \_\_\_\_\_ is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it may be detached for use as a burial certificate and filed with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If Item 21 is marked or Item 18 is shown

DHMH - 16 60M 7/84  
(VRA 15.4)

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 15413	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR		
Harold Dennis McConnell						July 7, 1985			5 14 85		M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		Month Day Year			76			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE / STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Massachusetts		USA					St Mary's						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Lexington Park		Amber House Nursing Home					Civil Service						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												20620	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland		St Mary's		Callaway						P.O. Box 55			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST Edward		MIDDLE Mcconnell			LAST Elizabeth Stewart								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			Box 55		
Yes USArmy		215-38-4074			Inez B. Mcconnell			Callaway, Md.			20620		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Respiratory Arrest												Minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) Severe Chronic Obstructive Lung Disease													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												Years	
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE
22a. I certify that (I/we) attended the deceased from <u>5/19</u> to <u>5/19</u> , 19 <u>85</u> , to <u>5/19</u> , 19 <u>85</u> , that (I/we) last saw the deceased alive on <u>5/19</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.												22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			22f. DATE SIGNED								
David Allen M.D.		Box 601 Leonardtown, Md.			5/19/85								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY		23f. STATE	
Burial		May 16, 1985		Holy Face			Great Mills, St Mary's, Md.						
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
W. Clarke Mattingley		Leonardtown, Maryland			MAY 17 1985			Leonardtown, Maryland					

RECORDED IN U.S. LIBRARY NO. 2

22-1121

A

136001

DIVISION ONE VITAL RECORDS 201 W. DEADERICK ST. MINTON, WIS.

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES.  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF CAPITAL RECORDS, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

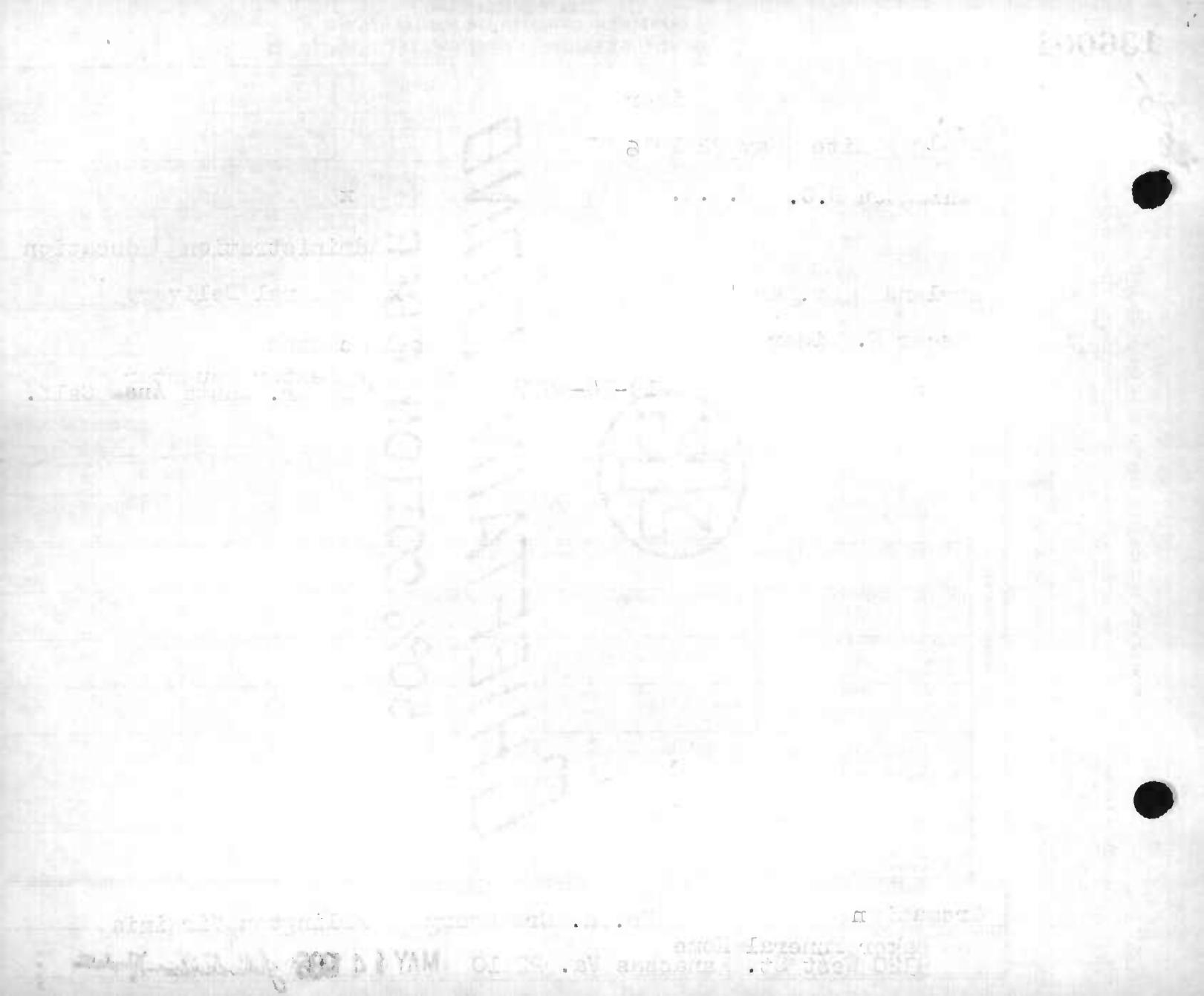
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5 4 1 4																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			20. DATE KNOWN OF EST. DEATH MATED			MONTH DAY YEAR			2b HOUR											
FLORENCE			Hiser			MONSON						<input checked="" type="checkbox"/> 5 4 19 85																	
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d HOUR										
Female		White		May 22 1936 48			YRS.						5 4 19 85						2:05										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Washington D.C.			U.S.A.									Leonardtown			St. Mary's Hospital			Administration			Education								
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE Maryland			13b. COUNTY St. Mary's			13c. CITY OR TOWN Compton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Geneeral Delivery			20627		
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			Mabel McNamee			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 219-34-8877			17. INFORMANT Catherine Lester Daughter 9731 Norfolk Dr. Santa Ana Calf.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												IMMEDIATE CAUSE (a) Shotgun wound of chest															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
												DUE TO, OR AS A CONSEQUENCE OF																	
												(b) DUE TO, OR AS A CONSEQUENCE OF																	
												(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															20. AUTOPSY? Body Only <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5-4- 19 85			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Park			21f. LOCATION STREET St. Clements Shores Pk.,			CITY OR TOWN			COUNTY St. Mary's, MD			STATE														
22a. I certify that I took charge of the remains described above, held on												Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion														
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE <i>Ann M. Dixon</i>			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 5-5-85																				
EXAMINER'S NAME (TYPE OR PRINT)			Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., MD 21201																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE MAY 14 1985			23c. NAME OF CEMETERY OR CREMATORIAL No. Va. Crematory			23d. LOCATION CITY OR TOWN Arlington, Virginia			COUNTY			STATE														
24. FUNERAL DIRECTOR NAME Baker Funeral Home 9320 West St. Manassas Va. 22110									25. DATE REC'D. BY REGISTRAR MAY 14 1985			25. REGISTRAR'S SIGNATURE <i>Julie Davidson Pendleton</i>																	

07/B  
25M

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))

DHMH - 17  
(VR A15 ME (5))

DHMH - 17  
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be deposited for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												15415 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			20. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
IDA MARTHA MORGAN									MAY 9, 1985						12:31a <sub>m</sub>
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		WHITE		MONTH DAY YEAR SEPT. 17, 1887			97			MONTHS	YEARS	MONTHS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
MARYLAND		U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			ST. MARY'S								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
LEONARDTOWN		RT. #2, BOX 45		HOMEMAKER											
13a. STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN LEONARDTOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RT. #2, BOX 45			20650		
14. FATHER'S NAME THOMAS		MIDDLE		LAST PILLSBURY			15. MOTHER'S MAIDEN NAME AMELIA			LAST DYER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT MR. FRANCIS A. MORGAN, LEONARDTOWN, MD.			17. ADDRESS RT. #2, BOX 45								
NO		219-56-2002													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Dehydration &amp; Decreased Mental Status</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Dehydration &amp; Decreased Mental Status</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>5/10/85</i> , to <i>5/11/85</i> , that (I) (we) lost saw the deceased alive on <i>5/10/85</i> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (did not) (did not) view the body after death.															
22b. SIGNATURE <i>D. C. Re</i>		22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN			22e. MEDICAL DIRECTOR			STAFF PHYSICIAN			22f. DATE SIGNED <i>5/11/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS			MEDICAL ARTS BLDG., LEONARDTOWN, MARYLAND							
DAVID ALLEN, M.D.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
BURIAL		5/11/85			ST. FRANCIS XAVIER			COMPTON, ST. MARY'S, MARYLAND							
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
					MAY 15 1985 <i>John Davidson-Mendell</i>										

ERSONAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. You are retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked death & shows any injury, or other traumatic event, the medical examiner should be notified to make

158032

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH15416  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MARY	MIDDLE EFFA	LAST REIHER	2a. DATE OF DEATH MONTH OCT. 01	YEAR 1897	2b. DAY May 25, 1985	2b. HOUR 11:59A M							
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH OCT. 01			YEAR 1897	6. AGE (IN YEARS LAST BIRTHDAY) 87	7. IF UNDER 1 YEAR MONTHS YRS	8. IF UNDER 24 HRS MONTHS DAYS	9. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.							
10. CITY OR TOWN OF DEATH Leonardtown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS			12b. KIND OF BUSINESS OR INDUSTRY Q.M. U.S.ARMY							
13a. STATE MARYLAND			13b. COUNTY ST. MARY'S			13c. CITY OR TOWN LEONARDTOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE CEDAR LANE APTS. 20650				
14. FATHER'S NAME FIRST CHARLES			MIDDLE V.			LAST HOFFECKER			15. MOTHER'S MAIDEN NAME FIRST CATHERINE			MIDDLE E.			LAST FLETCHER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 176-18-8309			17. INFORMANT 264 BRETON VIEW DRIVE JOHN R. REIHER, LEONARDTOWN, MARYLAND 20650			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2hr				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			b) <u>Cardiac arrest</u>			DUE TO, OR AS A CONSEQUENCE OF c) <u>Congestive heart failure</u>			2hr							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.																
22b. SIGNATURE <u>John F. Fenwick</u>			DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6-28-85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. Fenwick, M.D.			22e. ADDRESS Leonardtown, Md. 20650													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/29/85			23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON			23d. LOCATION CITY OR TOWN DREXEL HILL, DELAWARE, PA.			23e. COUNTY STATE				
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD. MAY 31, 1985 ADDRESS J. Edward Brinsfield																
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE																

122025



164018

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH15417  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
DAVID JOSEPH RILEY						MAY 31	1985			0840 M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		MAY 31, 1985							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
MARYLAND		U.S.A.				ST. MARY'S					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
PATUXENT RIVER		NAVAL HOSPITAL									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS / ZIP CODE		740 B GLEN VISTA 20670	
MARYLAND		ST. MARY'S		PATUXENT RIVER							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
		JAMES	ARTHUR	RILEY			PHYLLIS	P.	WILSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		740 B GLEN VISTA		ADDRESS			
NO		NONE		JAMES A. RILEY, PATUXENT RIVER, MD. 20670							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF											
(b) 22 WEEK GESTATION											
DUE TO, OR AS A CONSEQUENCE OF											
(c) MATERNAL INCOMPETENT CERVIX											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
19a.						<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <i>Gerard D. Kennedy</i> DEGREE <i>MD</i>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED <i>31 May 85</i>					
GERARD D. KENNEDY LCDR MC USN		NAVAL HOSPITAL, PATUXENT RIVER, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 6/5/85		23c. NAME OF CEMETERY OR CREMATORIAL BERLIN		23d. LOCATION CITY OR TOWN BERLIN		COUNTY CAMDEN		STATE N.J.	
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		ADDRESS JUN 10 1985		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John D. Kennedy</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP \_\_\_\_\_

2606

144087



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15418	
1. DECEASED NAME (TYPE OR PRINT) EDGAR FORREST EARL WILLIAMS				2a. DATE OF DEATH May 17, 1985			2b. HOUR 4:10 P.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 5, 1922			6. AGE (IN YEARS LAST BIRTHDAY) 62		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fla.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's			IF UNDER 24 HRS MONTHS HOURS MIN	
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY MD.				
13a. STATE Md.		13b. COUNTY St. Mary's		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 114 Essex Dr. South				
14. FATHER'S NAME Robert		15. MOTHER'S MAIDEN NAME E. Williams		16. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/>			17. INFORMANT Wayne I. Williams			ADDRESS Same as 13e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Vascular Accident</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) <i>Aspiration Pneumonia</i>											
19a. DATE OF OPERATION ____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ____			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) ____						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) ____			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>5/13/85</i> to <i>5/17/85</i> , that (I) (we) lost saw the deceased alive on <i>5/10/85</i> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <i>David Allen</i>		22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		22e. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED <i>5/18/85</i>		
22g. PHYSICIAN'S NAME (TYPE OR PRINT) David Allen, M.D.		22h. ADDRESS Leonardtown, Maryland 20650									
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 5/21/85		23c. NAME OF CEMETERY OR CREMATORIAL Myrtle Hill Cemetery			23d. LOCATION CITY OR TOWN Tampa			STATE Fla.	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.		25a. DATE REC'D. BY REGISTRAR MAY 21 1985			25b. REGISTRAR'S SIGNATURE <i>John W. Clarke</i>						

100



OKERST

148064

Items 18a 5/29/85 F#603 mtb

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5 REG. NO. 20

FOR  
1- STATE  
REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 18 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED	XX	MONTH	DAY	YEAR	2b. HOUR
Mark			D.	Woods, Jr.		5		17	1985	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD					
Male	Black	Jan. 23, 1985	YRS.	5		5-17 1985					
7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH		2d. HOUR				
Maryland		USA			X		7:13 a.m.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Lexington Park		Patuxent River Emergency Room			20653						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
Maryland		St Mary's		Lexington Pk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	102 Kent Drive				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
Mark		Daniel		Woods	Annette						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO						Mark D. Woods			same as # 13 above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: Acute Bronchopneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u>											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 to											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dennis F. Smyth, M.D. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201								DATE SIGNED 5-18-85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		5/21/1985		China Grove			Edgefield,		South Carolina		
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
W. Clarke Mattingley		Leonardtown, Maryland			MAY 23 1985			Julia Davidson Pendell			
BP											
DHMH - 17											
(VR A15 ME (5))											

